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Russian honorary professorship

ISNCC board member Virginia Gumley has been awarded the title of Honorary Professor by Moscow State University and Ulyanovsk State University, Russia.

Virginia Gumley, who is Director of Nursing/Nursing Education at the Shaukat Khanum Memorial Cancer Hospital and Research Centre in Lahore, Pakistan, was given the title in a special ceremony in January. The award was given in recognition of her outstanding achievements and in appreciation of her pioneering contribution to palliative care in Russia. Her work included education and training in palliative care for medical and nursing professionals.

In Ulyanovsk between 1990-1999 a fully comprehensive hospice and palliative care system was developed using a triparte model involving the Health Administration, the University and the Oncological Institute.

Virginia said: "I was very honoured and humbled to receive the award.

"The impetus to do this work has always come from the Russians. They own it and have continued to develop the concept in their regions so that today they are strong and empowered with services functioning successfully".

Award ceremonies were held both at Moscow State University and at Ulyanovsk State University. The ceremony in Ulyanovsk took place in the Lenin Memorial Hall in front of an audience including the regional governor and the president and vice-president of the University. After the conferring ceremony, the celebration continued with a cultural programme of music and dance.

Virginia plans to continue working closely with the Ulyanovsk Regional Hospice and the Ulyanovsk State University.

Back in Pakistan, Virginia has developed a Pain and Palliative Care Nursing Team over the last 6 years. The team of six specially-trained nurses provide palliative care for patients with advanced cancer in the hospital, as well as providing education and training for nurses both within the hospital and in Lahore. Virginia is currently working towards establishing a palliative care association in the Punjab.

Fire at the Royal Marsden

Nurses successfully evacuated 79 inpatients and as many outpatients in a major fire at the leading UK cancer hospital, the Royal Marsden NHS Foundation Trust in London.

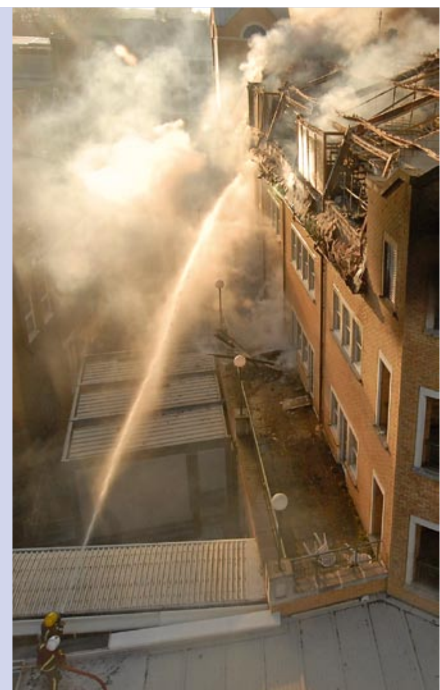
The fire that started on the roof of the building spread to the top floor of the hospital and was attended by over 200 firefighters in 25 fire engines. Patients were evacuated in less than an hour wrapped in blankets in winter temperatures of 3°C.

Several patients were in intensive care or theatre at the time. These patients were safely transferred to a nearby hospital accompanied by specialist nursing and medical staff.

All in-patients were transferred to neighbouring hospitals and their care provided by nurses, doctors and allied health professionals from the Royal Marsden. No patients or staff were injured during the fire.

Shelley Dolan, chief nurse at the hospital and board member of ISNCC said: 'Nurses at the hospital played a vital role in the successful evacuation of patients from a serious and potentially life-threatening fire.

"I think this brings home the importance of staff being trained in advance for such an event and would urge nurses to take the opportunity of any training that would help to prepare them. It is tempting to think that such an event will never happen at your hospital but as this recent fire at the Royal Marsden shows, it can unfortunately occur."



Supporting the family carers

I have recently had cause to reflect on the role of families in the care of people with cancer, particularly those with advanced disease. I believe nurses are in prime position to more effectively support the role of the family in cancer care but are often very focused on the patient as the primary care recipient.

There are some interesting research findings that suggest nurses might improve the patient's care by developing more family-sensitive approaches to their practice. As Barbara Given has consistently argued, carers help to improve the quality of care and to improve patient safety. Family-sensitive care suggests that we develop a greater understanding of the interrelatedness of the cancer experience between patients and family members, especially those in key support roles.

Evidence shows that family carers experience levels of distress as high as those experienced by the patient, and in some situations, such as end of life care, their distress may be significantly higher. There also appears to be an important connection between patient distress and carer distress such that as the distress of one individual increases so does the other.

This suggests that interventions to reduce distress might most effectively be targeted towards both patient and carer, raising important possibilities for future research.

Evidence also suggests that family carers are strongly motivated by the desire to ensure the quality of the care experience for the patient. This often results in the family carer taking on a significant burden, and in doing that neglecting their own needs related to physical, social and emotional health. Importantly, the family carer's distress increases when they are unable to ensure care quality.

Some authors have suggested the need for a focus on patient suffering as a means of mediating the experience of family carers — a focus that directly links to the carer's desire for a good care experience for their patient.

This is an interesting concept and provides a slightly different theoretical basis for involving carers as partners in nursing care. The concept would be that if nurses partner with carers in areas such as symptom management, prevention and reduction in physical deconditioning or in the provision of emotional support to the patient, then we are likely to not only improve quality of life for the patient but also for the carer.

Improved carer preparation and partnerships in care might conceivably enhance the carer's level of self-esteem and this in turn will potentially have a positive impact on their level of distress.

As cancer care increasingly shifts to ambulatory and community settings, the burden of care shifts to the patient and their family. Despite this, the family carer is largely hidden both in terms of their needs and in terms of the contribution they make to patient care. Cancer nurses around the world can greatly reduce the burden of cancer in our community by acting to raise the sensitivity of the cancer care systems to the need for partnerships with family carers.

One of the plenary sessions at the 2008 ICCN in Singapore will be *Partnerships in Care: A Collaborative Approach across the Cancer Journey*. This session will provide an opportunity for cancer nurses to reflect on a range of ways in which we can enhance the impact of what we do by collaborating with others. Let us not forget the potential partners in care that surround us in every care setting. Join us in Singapore to consider this and many other issues of importance to nurses around the world.

Sanchia Aranda
ISNCC president

Nepal report

Cancer Society Nepal has held an anti-tobacco education and awareness programme in a deprived area of Kathmandu, Nepal. Nearly 120 residents participated in the programme, the majority were women who were regular smokers. The women asked the cancer specialist who attended the programme about cancer, especially cervical and breast cancer. The event increased awareness about smoking and its effects.

Cancer registration needed

Registration systems for deaths and cancers are urgently needed in poorer countries, which have the majority of cancer cases, says a recent report.

Less than 20% of the global population is covered by cancer registration and only 30% by mortality registration, according to figures available for 2000.

Systems to collect statistics on the incidence of cancer were found to be less common in poorer countries. The report found that only 7% of the population of Asia was covered by systems for reporting incidence of cancer.

In Africa the figure was 8% while in Latin America it was 10%. In the absence of data from large sections of these populations, the IARC uses available data to estimate the total levels of cancer incidence and mortality.

Information about the 2007 Annual World Cancer Data Update is at www.iarc.fr

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Lessons learned in a smoke-free hospital: the ICO experience

This article describes how a hospital championed the anti-tobacco cause by implementing a smoke-free policy and reducing smoking rates among staff

One of the most effective strategies for reducing the harm from smoking is to introduce policies that promote smoke-free environments (Smoke Free Europe partnership, 2005). This strategy, included in the package of successful measures of the WHO Framework Convention on Tobacco Control (FCTC), (WHO, 2008; Neubeck, 2006) is crucial for protecting the health of smokers and non-smokers alike, as well as for sending a clear message that smoking in public places is not socially acceptable (WHO, 2008).

Going smoke-free is a challenge for every institution or organisation (Neubeck, 2006). Hospitals and health centres must set an example in terms of controlling tobacco consumption and championing compliance with the law. They should be taking the lead in implementing smoke-free policies. At the same time hospitals should ensure they provide information and advice about the dangers of smoking and give active support to smokers who want to quit (Batlle, 1991).

Many hospitals all over the world have implemented smoking bans with success. For instance, the Joint Commission on Healthcare Organizations (JCAHO) in the United States (Longo et al, 1995; 1998; Longo, 2001) and the European Network of Smoke-Free Hospitals (ENSH) have examples of initiatives (Méndez et al, 2004; García et al, 2006; Martínez & Garcia, 2007).

European code

The ENSH has developed a European Code that sets a clear guidance for the establishment of a smoke-free hospital. These policies should be part of global action involving organisations as a whole. They involve designing and enforcing a policy plan with the support of the management and the consensus of the staff, the patients and the visitors. In addition, the ENSH has developed some tools to facilitate the implementation of smoke-free hospitals (see **www.ensh.com**). These tools are undergoing a process of continuous revision and improvement based on cultural differences.

Following these trends, the Catalan Institute of Oncology (ICO), a Comprehensive Oncology Hospital in Barcelona, Spain, began the implementation of a smoke-free policy in 1997. Before the official launch, ICO gradually developed a smoke-free policy plan with the goal of achieving organisational change. This policy is outlined in table 1 below.

Step-by-step

ICO has introduced step-by-step bans on tobacco consumption. To begin with signs and some designated smoking areas were introduced. After that, three smoking areas were established in the hospital (two for employees and one for patients). By 2003, only one smoking area, exclusively for employees, remained. Finally, the definitive ban came in in July 2005, six months before the application of the national tobacco ban law in Spain in January 2006 (Martínez & Garcia, 2007.

During this period, the project leader team at ICO monitored tobacco consumption, attitudes and behaviour of staff members. The project team held five surveys, the baseline in 1997, and four more from 2001 to 2006. From 2003 the team monitored tobacco policies at the hospital by an annual self-audit questionnaire (Martinez et al, 2008). In addition we measured nicotine particles in some designated areas to evaluate the compliance with the ban in 2005 (before the tobacco law) and 2006 (after). These evaluations allowed the team to assess the impact of the implemented policies and to design and implant strategies to achieve a smoke-free hospital.

Table 1: Steps to smoke-free policies at ICO hospital

- Designate a smoke-free project leader team.
- Get the permanent commitment to the project at all staff levels.
- Maintain an internal and external communication support campaign.
- Provide signposted smoke-free indoor areas.
- Offer smoking cessation programmes to staff members.
- Provide training in smoking cessation to healthcare staff.
- Offer smoking cessation programmes to in and outpatients.
- Review the policy regularly and evaluate and monitor the development of the project using validated tools.

After the first phase of the project, which implemented a ban on tobacco consumption in hospital areas, the team concentrated on designing smoking cessation interventions. At that time, the results of our surveys showed a high rate of smoking prevalence among ICO staff (34.5%) in 2001. The team started a pilot cessation-support programme aimed at staff in 2002.

Nurses

Six nurses were trained in tobacco cessation, and the hospital offered nurses who smoked the opportunity to give up smoking with mentoring help for six months. In this programme the mentor was not just the therapist but was also giving personal support during the process of quitting.

In addition the mentor assisted the smoker to develop objectives and set targets as well as building self control. The mentor gave feedback and a critique of the smoker's progress. This pilot cessation intervention started with a group of nurses in order to increase their involvement in tobacco control activities at the hospital.

The project team considered that nurses were key players in the implementation of health programmes. This is because nurses are close to the patients and the community. They participate in all care activities and are able to introduce tobacco control activities into their day-to-day work. The effectiveness of the project was tested and it was found that 31.25% of people gave up smoking. At the same time it had helped to promote nurses who had quit smoking as role models (Martínez et al, 2005).

In a second phase, we expanded the tobacco cessation programme to the rest of the staff offering the help of a expert clinical nurse and free treatment (nicotine replacement therapy and Bupropion) for at least 6 months. More than 42 members of staff have received help in quitting from June 2005 to December 2006. Of this group, 12 had given up smoking after 6 months of follow up, which means a success rate of 26.5% (Riccobene et al, 2005).

According to our recent surveys smoking consumption rates have slightly decreased among ICO staff from 34.5% in

2001 to 30.6% in 2006. Occasional smokers have increased by 10% from 2004 to 2006 with a consequent decrease in the percentage of those who smoke every day (see table 2). Analysing smoking consumption by employee's categories shows a decrease in the number of smokers in all the groups.

The prevalence of smokers among health employees decreased from 30.2% in 2001 to 27.8% in 2006. When analysing results among doctors and nurses the results show that the percentage of smokers has decreased in all four surveys. Smoking prevalence among doctors went from 20% in 2001 down to 15.2% in 2006.

The smoking rate among nurses went from 34% to 32.6% in the course of five years. Additionally, our surveys show a marked decrease in the exposure to environmental tobacco smoke in the last five years. The percentage of employees who are completely free of smoke during their working shift has gone from 33% in 2001 to 91.4% in 2006 (Martinez et al, 2008).

Tobacco cessation programme

After the introduction of a tobacco cessation programme for staff the ICO coordinator group designed a strategy to offer a comprehensive tobacco cessation programme for patients of the hospital and for outpatients. All staff nurses were trained in giving advice on smoking cessation.

The team designed a counselling protocol to establish brief, opportunistic and unsolicited advice as a routine nursing intervention. Nurses of all wards and departments have the responsibility for asking all patients whether they smoked. Nurses should advise smokers to stop smoking and refer them to the available intensive cessation support programme.

Once the patient is informed, in a second level of responsibility, a smoking cessation specialist nurse visits each smoker individually (Riccobene et al, 2005). This nurse personally assists each patient during the process. Together the specialist nurse and the smoker design a plan to stop smoking. The nurse gives advice on how to manage the first days without tobacco and gives additional advice before discharge. During the ICO cessation programme all resident patients have access to nicotine replacement therapy and the support of a specialist nurse for six months.

After ten years of this project, the Catalan Institute of Oncology has improved and increased its smoke-free policies. The smoke-free project at ICO has kept this as a high priority within the institutional internal agenda. The project leadership has periodically reminded all employees about the existence of the tobacco control regulations and their aims.

These efforts and the continuous implementation of the project will in the future bring more positive outcomes in terms of a decrease in tobacco consumption. To date there is no clear relationship between the ban and a change in cessation rates. We can however say that the smoke-free project has produced important changes in smoking patterns, attitudes and behaviour of our employees.

In addition, we have to take in consideration the main barriers to our project: the high prevalence of smoking in the global population, particularly among nurses, and the low awareness of the importance of health professionals as role models for tobacco control.

Lessons learned

We can highlight some lessons learned from the ICO experience.

- First, the need to carefully plan policies and to spend resources and time to communicate the initiative.
- Second, the need to progressively evaluate the project and to design new and adequate tobacco control measures.
- Third, the importance of including staff members in tobacco control activities, training and giving them responsibility as advisors in the tobacco cessation programme.
- And last but not least, using lessons learned from other projects, such as those provided by the ENSH, guided ICO's project implementation.

To sum up; smoke-free hospital policies require correct implementation, enforcement and evaluation to achieve a public health impact and make hospitals an example in tobacco control.

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Table 2: Tobacco consumption among ICO staff, 2001–2006

	2001		2002		2004		2006	
	%	(n/N)	%	(n/N)	%	(n/N)	%	(n/N)
Smokers	34.5	(65/188)	32.8	(61/186)	34.0	(69/206)	30.6	(59/237)
Daily	83.1	(54/65)	90.0	(55/61)	84.8	(58/69)	74.5	(44/59)
Ever	16.9	(11/65)	10.0	(6/61)	15.2	(11/69)	25.5	(15/59)
Never smokers	38.3	(72/188)	44.6	(83/186)	37.9	(78/2060	39.4	(76/237)
Former smokers	27.1	(51/188)	22.6	(42/186)	28.2	(58/206)	30.1	(58/237)

Table adapted from Martinez et al, 2008

VIRTUAL CANCER CARE

Dispelling myths about cancer and its treatment

Despite huge public health campaigns in the developed world regarding the causes, effects and treatment of cancer there remain many different cultural and societal myths, which need to be challenged sensitively and effectively. I recall ten years ago coming across a doctor working in a hospice on a teaching visit to Moscow who wore a full operating theatre outfit, including face mask, to interview the patients she saw.

It became clear in conversation that she feared catching cancer herself and the uniform was, in her eyes, a precaution against cross infection. Experienced professionals often come across such false beliefs, so it's worth finding what the internet has to offer to help in such situations.

Discovery Health

http://health.discovery.com/centers/cancer/top10myths/top10myths.html

This generic health care website presents a 'top ten cancer myths' page which is the result of a survey conducted in the US to discover the most popular misconceptions about cancer. The information is presented well, with each item explored giving the origin of the myth followed by a detailed section entitled 'the reality'.

Cancer Backup

http://www.cancerbackup.org.uk/Resourcessupport/Practicalissues/Cancerandolderpeople/Commonmyths

This award winning UK site has been reviewed a number of times before, so it comes as no surprise to find a useful section devoted to challenging some of the most common cancer myths. Areas covered include pain, morphine addiction, hospice care, ageism and treatment.

The Myth of Cancer

http://www.buchholzmedgroup.com/articles/PDF/Myth.pdf

I am a great fan of the power of story telling as an educational tool. This short and highly readable article puts a different and positive stance on the myth of cancer by using the story as a metaphor for our fears, and guides us towards a more reasoned perspective. This is not a website, but a document on a US website that can be read on line or downloaded in seconds and saved to your computer to be read at a later date or printed out. It is in pdf format which means you need to have Adobe Acrobat Reader on your computer to read it. If you do not have this it is readily available to download free from the Adobe website.

Mayo Clinic

http://www.mayoclinic.com/health/cancer/HO00033

This page on the Mayo Clinic website concentrates on the specific myths surrounding cancer treatment and looks at attitude, technology, drug companies, daily activities and a range of treatment issues. It is possible to print the article and to view it in larger type if needed. There are also some useful links to follow up articles on the same website. The information is regularly reviewed and the articles are quick to load.

Worth a look

Email hoaxes and chain mail

http://www.cancer.org/docroot/MED/MED_6_1_Rumors.asp

This very useful page on the American Cancer Society website takes a critical and balanced look at the plethora of cancer myths that circulate on the internet from time to time in email and chain letter format. They can appear very convincing and a resource such as this could be very useful for practitioners who are challenged by patients about these well intentioned, but often misleading messages.

Health Translations Directory

http://www.healthtranslations.vic.gov.au/bhcv2/bhcht.nsf/PresentDetail?Open&s=The_myths_about_cancer

This Australian website has a brief downloadable pdf document about cancer myths that gives the basics for any practitioner to use with their patients and their family.

Whilst accurate factually, the leaflet is not particularly well laid out. My main reason for recommending it is because it is available to download in 12 different languages and so has the potential to reach out to many indigenous and immigrant communities in many countries where such myths remain strongly embedded in societial beliefs.

Robert Becker, Macmillan Senior Lecturer in Palliative Care, Staffordshire University Faculty of Health and Sciences and Severn Hospice, UK

Exciting scientific programme for Singapore

The Scientific Planning Committee for the 15th ICCN in Singapore has received more than 500 abstract submissions from nurses from 46 countries.

Co-chairs of the Scientific Planning Committee Gek Phin Chua and Patsy Yates have led the committee and 40 international reviewers to peer review each abstract.

Some of the best abstracts have been selected for presentation in the more than 30 concurrent sessions that are planned for the conference. Concurrent session will address an enormous range of topics relevant to cancer care.

Those attending these sessions will learn about some of the latest developments in nursing care of people with cancer at all stages of their journey, and will hear the perspectives of practitioners, researchers, managers and educators in the field.

Plenary sessions will address topics including tobacco control, survivorship, issues for the older person with cancer, treatment developments, palliative care, East meets West, and coordination of cancer care.

With the increasing emphasis being placed on safety and quality issues in cancer care, the programme will include a session which provides specific examples of patient safety initiatives in cancer care, highlighting some best practice examples from different regions of the world.

There will also be an interactive panel discussion session with some of the world leaders in cancer nursing who will be asked to provide responses to the challenges associated with securing a strong cancer nursing workforce for the future.

More than 200 poster presentations will be given at the conference. As in the 14th ICCN, the poster presentations for this year's conference will have a high profile in the conference programme with dedicated times for discussions with authors and awards given.

The 15th ICCN will be held from 17–21 August 2008, at the Suntec International Convention and Exhibition Centre in Singapore.

The theme for the conference is *Creating Partnerships, Championing Progress, and Celebrating Practice*. The Scientific Planning Committee selected this theme for the positive and forward thinking messages it sends about cancer nursing in an international context.

The 15th ICCN promises to provide an outstanding opportunity for developing knowledge of cancer nursing and how nurses can contribute to cancer control efforts around the world. For more information visit **www.isncc.org**.

Tobacco use during pregnancy increasing

Rates of tobacco use during pregnancy, as well as exposure of pregnant women and their young children to secondhand smoke, are growing threats to health in several low and middle-income countries, according to findings from a National Institutes of Health study.

Approximately 8,000 pregnant women were surveyed at five sites in Latin America (Argentina, Uruguay, Ecuador, Brazil and Guatemala), two sites in Africa (Zambia and the Democratic Republic of the Congo) and three sites in Asia (two in India and one in Pakistan).

Historically, the prevalence of smoking among women in the developing world has been very low, in part because of strong cultural constraints against women's tobacco use.

This study, the first of its kind, found that as many as 18% of pregnant women currently smoked cigarettes, up to one-third used smokeless tobacco, and as many of half were regularly exposed to secondhand smoke in the nations studied.

Uruguay and Argentina had the highest levels of smoking during pregnancy across all ten study sites (18% and 10% respectively). In the Indian sites one-third of all pregnant women used smokeless tobacco in Orissa and about 20% of pregnant women in Karnataka were often exposed to secondhand smoke.

The highest levels of secondhand smoke exposure were found in Pakistan, where about half of all pregnant women and their young children were frequently or always exposed to secondhand smoke.

In the Democratic Republic of the Congo, 40% of respondents reported that they had tried smokeless tobacco at least once, and 6% had used smokeless tobacco while pregnant.

"These data highlight the urgent need to adopt proven measures to prevent and control tobacco use — both cigarettes and smokeless tobacco — and secondhand smoke exposure of women and girls worldwide," said Linda Wright, scientific director of the Global Network, Center for Research for Mothers and Children, National Institute of Child Health and Human Development.

Bloch et al (2008) Tobacco Use and Secondhand Smoke Exposure During Pregnancy: An Investigative Survey of Women in 9 Developing Nations. *American Journal of Public Health*, Published online February 28, 2008 10.2105/AJPH.2007.117887.

EDUCATION COLUMN

Nurses as educators: cancer education for faith leaders

A cancer diagnosis, recurrence or advancing disease are all occasions when an individual may have heightened spiritual awareness and significant spiritual needs (O'Brien, 2003). The spiritual needs may range from a searching for meaning to the need to review their beliefs, find hope or support to carry out the religious practices or rituals that are significant to them. (Taylor, 2003).

They may be seeking answers or comfort from a religious faith that they have held for a long time, or that they are turning to in this time of crisis. If an individual is in hospital, they may gain support in this area from the nurses caring for them or the chaplaincy or pastoral care team. However as hospital stays in the UK become shorter, individuals will be looking elsewhere, perhaps turning to their local church or faith centre.

It is our experience as an organisation that the faith leaders and lay care teams of these organisations may be under-equipped to offer the support needed, primarily because their understanding of cancer and its treatment is very limited.

Workshop

Caring for the individual with cancer in your church is a one day workshop run at The Royal Marsden Hospital in London UK to provide education for this hidden, but essential, part of the support team for some individuals with cancer. It was designed so that it would be accessible to faith leaders of any religion but has primarily been attended by those of a Christian perspective, reflective undoubtedly of the 70% of patients admitted to the hospital, who declared their religious denomination as Christian.

The day is designed to be a mixture of factual information and practical tips with an opportunity to reflect on the philosophical and theological issues that may arise when offering spiritual support to an individual with cancer.

The day begins with a very factual exploration of cancer answering basic questions, such as what is it? why does cancer develop? and how does it spread? This introductory session also helps to begin to dispel some of the myths that are held about cancer such as: cancer = death. National statistics are used to provide some perspective and illustrate that there are more people living with cancer who need support than there are dying of cancer.

Discussion

This is followed by a discussion about the theological issues and importantly an acknowledgement that there are no easy answers. This is an opportunity to remind faith leaders that often individuals are looking primarily for somebody to listen to their philosophical questions and only secondly for help answering those questions.

To give a sense of reality this is followed with presentation of the patient's journey through the health care system, giving an explanation of the diagnostic tests, types of treatment and possible side effects. During this session, information is also given about the voluntary agencies that offer advice and support.

Seminar

A seminar looking at the challenging questions and how to answer them enables the participants to discuss the issues that they face. Guidelines about what not to say are given and the participants are encouraged, in groups, to work out their own answers.

A cancer patient comes to tell how their local church helped and hindered them, reminding the participants that the hardest, most challenging time can be when the treatment is finished A pastor of a local church talks about the practical role a local church can have in supporting an individual and their family at this time and challenges participants in respect of prayer and confidentiality. The day ends with a reflection on hope, its importance for the present and the future.

Overall participants evaluated the workshop positively: "Extremely helpful to bring together the practical realities facing those being treated for cancer with the spiritual/emotional aspects of suffering". This day is an opportunity for nurses to collaborate in respect of the spiritual needs of individuals with cancer.

Sara Lister, Assistant Chief Nurse/Head of School, Royal Marsden NHS Foundation Trust, London UK
For further information please contact sara.lister@rmh.nhs.uk

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RESEARCH COLUMN

Using communities of practice in oncology nursing research

Communities of practice (CoPs) are groups of people who share a concern or a passion for something they do and learn how to do it better as they interact regularly (Wenger et al 2002). The concept is not a new — CoPs have been used for effective knowledge sharing and creation in business, education, organisational development and health services. What makes communities of practice of particular interest to us is that the absence of hierarchical or geographic boundaries makes it easier to build capacity in research, management and policy-making.

CoPs have three essential elements: a shared domain; a defined community of participants; and a collective goal to improve practice:

- *Domain* refers to people from the same discipline (oncology nursing) with a shared goal to improve themselves and their specialty.
- *Community* refers to the relationships the participants foster and develop — it is interactions over time that creates the community.
- *Practice* refers to developing shared repertoires of resources, experiences, stories, tools and ways of addressing recurring problems.

CoPs have several benefits. From a participant perspective, the CoP provides access to expertise, builds confidence and provides opportunities for meaningful collaboration. From an organisational viewpoint, the CoP offers opportunities to enhance problem solving, share knowledge, create synergies across sites, and support innovation.

Establishing a CoP

When establishing a CoP, there are four areas to consider:

- First, CoPs occur naturally and emerge in response to an interest or issue that affects practice. CoPs are nurtured by inner motivation and run counter to most organisational structures; yet sometimes the CoP needs organisational support to begin the process.
- Secondly, the COP needs clear goals and objectives that are shared by the members.
- Third, it is essential to organise regular events that provide a forum and set the rhythm of the community.
- Finally, sharing stories and successes is motivating and helps to build and apply knowledge generated through member interaction.

The Information Authority of the National Health Services (IA, NHS, 2004) produced a comprehensive guide on the development of CoPs. The guide describes seven stages of development:

- Stage 1: identify a common agenda,
- Stage 2: build trust and commitment,
- Stage 3: establish norms and principles,
- Stage 4: set early 'wins',
- Stage 5: recruitment and retention of members,
- Stage 6: internal and external communication,
- Stage 7: implement the 'products'.

The CoP–R

The Community of Practice – Research (CoP–R) is an example of how the concept can be exploited by individuals who are passionate about research and wish to share and build knowledge. The belief that evidence-based nursing practice includes the collaborative efforts of nurses working in both academic and practice environments was the stimulus for establishing the CoP–R.

At its inaugural meeting, the group identified its fundamental elements according to Wenger (2002) and outlined its terms of reference. The fundamental elements are: *oncology nursing* as the shared domain; *research* as the shared practice or collective goal; and the community of people sharing this knowledge and goal are *nurses across Ontario* [a region in Canada] *who have an interest in oncology nursing research.*

The group's terms of reference include:

i) providing leadership in setting an agenda for oncology nursing,
ii) sharing knowledge and expertise through partnerships, mentoring and networking,
iii) implementing multi-site research activities,
iv) promoting knowledge transfer through links with other oncology nursing stakeholders.

The definition of research used by the CoP-R is broad and reflects the implementation of research studies and other activities including the exchange of ideas, learning about research methodologies, evaluating research studies, and knowledge brokering.

This definition helps to broaden the parameters of our membership. We have no educational or role prerequisite for membership, the only requirement is an interest in research. There is no hierarchical structure and membership is built through sharing, trust and commitment.

Currently, we are a community of 22 individuals including clinical nurses, researchers, educators, and organisational leaders.

As members of the CoP–R live across a large region of Canada, the main forums for communication are quarterly teleconferences, email and a face-to-face meeting at the annual Canadian Association of Nursing in Oncology.

Smaller working groups communicate by email and teleconference to implement research activities. For example, one working group of the CoP–R developed and conducted a pilot study to examine telephone-based nursing services for oncology patients in Ontario and recently had the study findings published (Stacey et al, 2007).

Our CoP-research began in 2005 and over the past two years we have tested the waters about what the potential for this group might be. While we had an "early win" with our telephone-based nursing research project, our group recognises the need to develop in other ways. We plan to direct future efforts to other objectives reflected in our terms of reference. For example, as a collective we can provide leadership in setting an agenda for oncology nursing research in our province. Through the combined expertise in our membership we have the potential to provide education and mentorship to facilitate the development of new researchers and increase awareness of oncology nursing research.

The future

The Communities of Practice concept is a vehicle for effective knowledge sharing and creation. Competing agendas for time and keeping up the momentum for member interest are challenges for group sustainability. Meeting these challenges requires building on the strengths of the CoP concept.

For our CoP model, the ability to share knowledge, promote research and have an impact in advancing oncology nursing lies in our community of individuals who represent expertise from all areas of nursing. A CoP is an opportunity to bring together individuals with a commitment to develop and validate best practices over time through sustained interactions.

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References:

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